

Case Report

Can Masturbatory Guilt Lead to Severe Psychopathology: A Case Series

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ABSTRACT

Masturbation is common in all societies. Despite being common, it is admonished culturally and almost all religions prohibit masturbation and consider it an act of immorality. The prohibition for masturbation leads to a lot of cultural beliefs, including certain myths, which influence sexual behavior of the person. The impact of these common cultural myths associated with masturbation, are clinically understood as Dhat syndrome and masturbatory guilt. Although there is a reasonable literature on Dhat syndrome, there is limited literature with regard to masturbatory guilt especially linking the same with axis-I psychopathology. In this case series, three cases of masturbatory guilt are presented in whom masturbatory guilt was associated with manifestation of severe psychopathology. This report suggests that masturbatory guilt must be enquired for in patients presenting with severe mental disorder.

Key words: Masturbation, masturbatory guilt, psychopathology

INTRODUCTION

Masturbation is a solitary sexual activity, used to achieve sexual pleasure. It is common in all the societies.^[1] Despite being common, it is admonished culturally and almost all religions prohibit masturbation and consider it an act of immorality.^[2-4] The prohibition for masturbation leads to a lot of cultural beliefs, including certain myths, which influence sexual behavior of the person.^[1,5] The impact of these common cultural myths associated with masturbation, are clinically understood as Dhat syndrome and masturbatory guilt. Although there is reasonable literature on Dhat syndrome,^[6] there is a limited literature with regard to masturbatory guilt

especially linking the same with axis-I psychopathology. Evidence also suggests that many patients with Dhat syndrome have masturbatory guilt with comorbid anxiety and depressive symptom/disorder. Although certain other culture bound syndromes like Amok^[7] are more closely associated with psychosis, Dhat syndrome is usually not linked to psychosis *per se*.

As there is no data linking masturbatory guilt with severe mental illnesses like psychotic disorders or recurrent depressive disorders (RDDs), in this case series we present three cases in which masturbatory guilt contributed to or was associated with development of severe psychopathology.

CASE REPORTS

Case 1

A, 25-year-old unmarried male, Hindu by religion, who was pre-morbidly well-adjusted and did not have any past or family history of mental illness presented with an insidious onset illness of 3 years duration characterized by a delusional belief that his penis

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had started retracting into his abdomen. He would frequently check his phallus and voice concerns about his sexual potency after marriage. He attributed his symptoms to his masturbatory habit, which he has been practicing for pleasure since the age of 14 years. Over the period, his distress and preoccupation with his penis retracting to abdomen increased, started remaining distressed and anxious, had poor attention and concentration, worries about future mainly related to his sexual potency, poor socialization, decreased sleep and decreased appetite. He also stopped masturbating completely and started complaining of passing whitish sticky fluid from the penis after passing urine, which he considered to be semen. At the initial contact with a psychiatrist after 3 months of onset of symptoms, he was treated with tablet amisulpride 150 mg OD for a month. Within 2 weeks of starting of amisulpride, he stopped complaining that his penis was retracting into the abdomen. His interaction also improved marginally, but the complaints of passage of whitish fluid from penis after passing urine persisted along with the belief that all his symptoms were due to indulgence in masturbation. He continued with amisulpride for 6 months and then stopped the same on his own. On the advice of family members, he started consulting faith healers. Within 6 months of stopping amisulpride, he started voicing that his body was feminine in nature. He would say that the muscle mass of his limbs was like females, in that his upper limbs were deviated laterally at elbow joints, which were prominent when he walked and his thighs were more roundish rather than being flat, which according to him was commonly seen in females. He again attributed all his symptoms to excessive masturbation and passage of whitish discharge from the penis, which as per him was semen. He started praying to God, watched religious programs and consulted priests and faith healers for the solution to his problems.

Over the next 2 years, in addition to the above symptoms he started voicing that his penis and testicles would disappear into his abdomen and ultimately he is going to lose them as these would shed into the stools. He further voiced that if his penis vanished he might not be able to pass urine which in turn would accumulate in his body and he might fall sick. He harbored all these beliefs firmly despite reassurance from the family members. Gradually, he developed pervasive sadness of mood, anhedonia, lethargy, worthlessness and would often voice that there are bleak chances of improvement in future. His appetite, sleep and self-care also worsened and he became homebound. Over these 2 years, he was again treated with tablet amisulpride up to 150 mg/day, but he did not show any improvement and had poor compliance with medications. Continuation of symptoms led to

his admission to our in-patient unit. Mental status examination at the time of admission reflected sadness of mood, ideas of hopelessness, worthlessness, masturbatory guilt, suicidal ideations, bizarre somatic delusions, impaired abstraction along with poor insight. He was diagnosed with undifferentiated schizophrenia along with severe depressive disorder without psychotic features, Koro and Dhat syndrome. His routine investigations, hormonal profile (thyroid function test, serum testosterone levels and serum prolactin levels) did not reveal any abnormality. He was treated with tablet olanzapine 25 mg/day, tablet escitalopram 25 mg/day and modified bitemporal electroconvulsive therapy (ECT) with which his depression remitted. His delusions also subsided. However, he still continued to attribute all his sufferings to the excessive masturbation. Patient was educated about normal anatomy and physiology of reproductive system as well as gastrointestinal system with the help of diagrams and pictorial representations. Following this his distress associated with masturbatory guilt reduced and he was discharged after 6 weeks from the in-patient unit. During the next 1 year, he kept on following up regularly, took the medications with good compliance and started working.

Case 2

Mr. S, a 47-year-old married farmer, belonging to Hindu religion, from a rural background, who was pre-morbidly well adjusted, with no family history of mental illness presented with an episodic mental illness since the age of 18 years, suggestive of RDD. The first episode of moderate severity (suggestive of moderate depression without somatic symptoms) occurred when he was 18 years of age. The episode was precipitated by patient's worries of passing semen in urine, which he believed would lead to gradual decline in masculinity, something he had learnt from his peers. Further, he was told by his peers that because of the fact that he has been masturbating regularly he is going to lose his masculinity at an early age. He consulted faith healers and Ayurvedic practitioners who further strengthened his belief that masturbation at the early age was responsible for current passage of semen in urine and his weakness was due to the same. Following this, he started remaining worried and tense and would have negative thoughts related to his sexual performance in future. He developed lots of guilt around his masturbatory habit since the young age. The family members persuaded him to get married and assured him that these symptoms would remit after marriage, but he refused to marry. Gradually, he developed syndromal depression which lasted for a period of 3-4 months. Although his depression remitted without treatment but he continued to harbor the belief that his sexual potency is going down and he was passing semen in urine and attributed the same to the masturbation during the earlier years. This was

associated with significant guilt. Due to all these he would often complaint of weakness, lethargy but was able to work. Under social pressure, he got married at the age of 23 years, although had no sexual dysfunction yet was not satisfied with his sexual performance and continued to harbor the masturbatory guilt.

In the next 9 years, he consulted many faith healers and traditional healers, continued to harbor the masturbatory guilt and passage of semen in urine. Owing to this, he would take lot of precautions in his dietary habits and sexual activity. At the age of 27 years, he again developed severe depressive episode without psychotic symptoms for which he was treated with antidepressant medications and ECT by a psychiatrist. This episode was precipitated possibly by the stress of expectancy to have a second male child, when his wife was pregnant for the second time. He started thinking that due to past masturbatory habits and continued loss of semen in urine he would not be able to father a male child. This episode lasted for 6 months. After this he remained euthymic until the age of 33 years but continued to harbor the masturbatory guilt and passage of semen in urine. At the age of 34, he had the third episode of depression amounting to moderate depressive episode without somatic symptoms. During this episode he frequently voiced his masturbatory guilt. During this episode, he was started on tablet sertraline 100 mg/day with which he achieved remission and was maintained on the same for prevention of relapse. He was admitted to our in-patient unit with severe depression without psychotic symptoms, which was his fourth episode at the age of 47 years, precipitated by poor compliance with sertraline. During this episode, there was a suicide attempt which led to admission to the in-patient unit. On mental status examination, he had depressive facies, marked psychomotor retardation, harbored ideas of worthlessness and pessimistic views of recovery. He strongly believed that his illness was a result of gradual loss of semen in urine and excessive masturbation in childhood. He reproached himself for doing masturbation that led to his current symptoms. He also actively voiced suicidal ideations. Diagnoses of RDD, currently severe depressive episode with psychotic symptoms, Dhat syndrome and intentional self-harm were entertained. His routine investigations did not reveal any abnormality. His thyroid function test was suggestive of hypothyroidism. On Hamilton Depression Rating Scale, he scored 32 at the time of admission. He was treated with capsule venlafaxine 225 mg/day, olanzapine 10 mg/day, thyroxine 25 µg/day along with a course of modified bitemporal ECT. With the above treatment, he achieved remission over the period of 3 weeks. After remission he was educated about the normal anatomy and physiology of sexual functioning and all his myths related to masturbation,

formation and passage of semen were clarified. He was discharged from the hospital after 4 weeks of hospital stay and continued to function well and was compliant with the medications.

Case 3

Mr. SS is a 38-year-old married man belonging to a Hindu nuclear family of urban background, who had family history of depressive disorder in his brother and mother and obsessive compulsive disorder with comorbid RDD in one of his sisters. He presented with RDD, current episode severe depression with psychotic symptoms.

Mr. SS had four episodes of depression since the age of 28 years. The first two episodes (occurring at the age of 28 and 34 years) were severe in intensity, but were not accompanied by psychotic symptoms and each lasted for 5-6 months. He was treated with Ayurvedic medications in first episode and second episode was treated with desvenlafaxine 100 mg/day.

He continued the antidepressant medications for next 1½ years with regular compliance, but stopped the same thereafter. Within 6 months of stopping antidepressant, he had recurrence of symptoms, amounting to severe depression with psychotic symptoms during which he also attempted to end his life. He visited our out-patient during this episode. He was initially treated with tablet imipramine 200 mg/day, tablet olanzapine 10 mg HS and six effective ECTs. With this treatment, he achieved remission but developed mild cognitive deficits, mainly involving the immediate and recent memory, which led to mild dysfunction at work. After remission, he followed-up irregularly and was poorly compliant to medication. Earlier he would consume alcohol on social occasions, but now started taking alcohol almost daily and developed tolerance, craving and withdrawal associated with alcohol. Despite repeated advice he continued to be poorly compliant and took alcohol daily. He again had relapse of depressive symptoms at the age of 38 years, which was characteristic of severe depressive episode with psychotic symptoms. The episode was characterized by sadness of mood, anhedonia, marked disturbance in bio-functions (sleep and appetite), ideas of hopelessness, worthlessness, guilt, suicidal and homicidal ideations and delusions of nihilism along with increased consumption of alcohol and marked socio-occupational dysfunction. Initially attempts were made to increase his medication compliance and keep him abstinent from alcohol, but despite good compliance with imipramine 200 mg/day and abstinence from alcohol for 8 weeks he did not show improvement. Later, imipramine was increased to 250 mg/day, along with tablet olanzapine 15 mg/day, but this also did not lead to any improvement over next 4 weeks. Following this he was shifted to Capsule.

Venlafaxine 225 mg/day, but did not improve. He was offered ECT and in-patient care, but refused ECT because of past experience of cognitive dysfunction and refused admission because of poor social support. On one occasion he poisoned the water at home with the intention of ending his own life and that of all his family members, but later informed everyone. Within few days, he attempted suicide by ingesting 70 tablets of imipramine and had a generalized tonic-clonic seizure. He could be revived and was shifted to the psychiatry in-patient unit for further care. For the first time he disclosed about masturbatory guilt and loss of semen with characteristics beliefs suggestive of Dhat syndrome, which he harbored prior to the first episode of depression and attributed his depressive illness to the same. The belief that all his symptoms of depression were due to excessive masturbation since early childhood was delusional in nature. In addition, he also had delusion of nihilism. He was diagnosed with RDD current episode severe depression with psychotic symptoms; alcohol dependence syndrome currently using the substance, intentional self-harm; imipramine toxicity and Dhat syndrome. His physical investigations did not reveal any abnormality. Beck depression inventory rating score was 35 at the time of admission. The dose of capsule venlafaxine was increased from 225 mg/day to 262.5 mg/day, tablet olanzapine was continued at 15 mg/day along with thiamine and folic acid supplementation. He was also treated with ECT. With treatment he achieved remission within 6 weeks. Non-pharmacological interventions in the form of cognitive remediation, activity scheduling, progressive muscle relaxation, psycho-education about illness and sex education was also done. He was discharged after 7 weeks of in-patient stay and has been maintaining well since then for the last 7 months.

DISCUSSION

Masturbation was ignored in the scientific for a long time until the publication of *Onania* around 1712 when it assumed the shape of a discrete disease and an ethical problem.^[1] Historically, the negative connotations attributed to masturbation was not limited to any specific ethnic group but has been propagated by many writers across the globe.^[8-11] Sigmund Freud was of the opinion that masturbation contributes to hysteria and neurasthenia.^[12]

Sexual practices studied by many researchers from the ethnophysiological perspective have provided insights into this not much talked about subject especially in the Indian subcontinent. In the Indian culture sexuality is understood from the perspective of morality and ethics and emphasis is laid on self-control. The Hindu religion expects its men to follow "*Brahmacharya*" with

the goal of achieving control on all the "*Kriyas*" or senses. In this context "*Kama*" or lust is considered to be the most unstable experience which makes one to potentially lose control over one's desires.^[13] Semen is believed to be a elixir of life and conservation of semen is considered to promote physical and mental health. The Ayurvedic medical treatises (*Susruta Samhita*) mention that the production of semen starts with the digestion of food into chyle which is the source of blood. Blood in turn is transformed into flesh and bones, which in turn produce semen in the marrows.^[14] Therefore, semen is the vital essence of life not only for men, but also for women who get it from men during sexual intercourse. Accordingly by maintaining "*Brahmacharya*" or celibacy one retains his semen which becomes a source of greater wisdom, enhanced knowledge and leads to spiritual enlightenment.^[2] Even though, there has been immense development in the medical sciences and education in India with significant influence of the west but still most people believe in the basic principles of ancient knowledge and put emphasis on self-regulation especially with regard to sexuality for positive health.^[15,16] Accordingly, it is a common preoccupation among the Indian unmarried men of any religious denomination that bodily and mental weakness results from semen loss by methods other than heterosexual intercourse and thus associated with sexual anxieties.^[17-20] Masturbation is associated with negative moral values in the Indian subcontinent. The interviewees in one study believed it to be a cause for various health problems as well as a sinful and shameful act.^[19] Instead the participants viewed visiting a sex worker as an appropriate outlet for semen release rather than masturbation. Likewise, in a similar study none of the participants accepted masturbation to be a method to relieve "tension" or as a mode of pleasure.^[16]

People who indulge in the act of masturbation have associated guilt feelings, depending on their level of belief/faith on the cultural belief system. In the Indian subcontinent, the "masturbatory guilt" is in general seen as part of the Dhat syndrome. However, there is lack of literature evaluating the relationship of masturbatory guilt with psychopathology. There is only one case report in which the authors reported the role of masturbatory guilt in development of depression and sexual dysfunction in a young male.^[21]

A total of 2 out of the 3 cases described in this case series fulfill the criteria of Dhat syndrome. One patient met the criteria for Koro, 2 patients had RDD and one patient had psychosis. In patients with RDD, accentuated masturbatory guilt appeared as a clinical manifestation of depression and in one of these cases masturbatory guilt as a precipitating event for the

first episode of depression. In the patient presenting with psychosis, masturbatory guilt influenced the manifestation of psychosis and was intertwined with the psychotic symptoms. In at least 2 of the 3 patients, masturbatory guilt was in the form of delusional belief. The relationship between Koro and masturbatory guilt suggests that patients with Koro also need to be evaluated for masturbatory guilt. Some of the traditional beliefs also suggest that well preserved semen is associated with the birth of male child^[18] and the same reflected in one of our patient that led to relapse of depressive episode.

In the current psychiatric nosological systems, cultural factors are not given due importance while evaluating the mentally ill-patients from the perspective of their role in causing the disorder, their influence on manifestation of psychopathology and treatment related behaviors and practices. Our case series highlight the importance of cultural factors in the development and manifestation of psychopathology. The cases described in this case series highlight the fact that socially shared sexual anxieties remain deeply rooted in the Indian psyche. This may be partly due to perpetuation of the same by the traditional medical practitioners and advertisements about the consequences of wrong sexual practices especially in childhood. The somatization of guilt and psychological anxiety associated with semen loss might have more than known consequences on the individual.

Clinicians are often faced with dilemma in dealing with patients presenting with masturbatory guilt. As masturbatory activities are frowned in the western societies too, many researchers have looked at the benefits and negative consequences of this habit. Some evidence suggests that higher frequency of masturbation is associated with higher depressive symptoms,^[22-24] immature defense mechanisms, dissatisfaction with one's mental health and life in general,^[25] less happiness,^[26] impaired sexual functioning,^[27-32] higher dissatisfaction with relationships and less love for partners.^[25,27] In fact, some of researchers have reported that excessive masturbation is related to increased risk of prostate cancer.^[25] On the other hand, some of the authors suggest that masturbation is a healthy behavior that improves mood, lessens the risk of prostate cancer and helps developing sexual interests.^[33] Taking all these into account, it often becomes difficult to suggest whether masturbation *per se* is a healthy or unhealthy behavior. Further, when it can be considered as "overdoing" the act is also not clear.

There is lack of literature from India to understand the role of masturbation and associated beliefs its role in development of psychopathology. Hence, there is a need to expand the literature in this area.

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